societies

MDPI

Review

Transgender Health between Barriers: A Scoping Review and Integrated Strategies

Davide Costa

Department of Law, Economics and Social Sociology, University "Magna Graecia" of Catanzaro, 88100 Catanzaro, Italy; davide.costa@unicz.it

Abstract: Transgender people have garnered attention in recent years. They have different health problems; the fact, however, that they belong to a minority means that this is characterized by complex mechanisms of stigmatization. This paper aims to analyze the current literature on the barriers to health services encountered by transgender people. This scoping review is based on the following research questions: (1) What are the main barriers to health care encountered by transgender people? (2) Is it possible to organize these barriers according to a macro-, meso- and microanalysis approach? (3) What are the main characteristics of the barriers to health care encountered by transgender people? (4) Are there significant relations between the different types of barriers? The review was undertaken following the PRISMA extension for scoping reviews. In total, 32 studies were included from which three types of barriers with different subcategories were identified: health system barriers, social barriers, and individual barriers. In conclusion, due to the complexity of gender issues and barriers to health care, a multidisciplinary approach is necessary. In this regard, some integrated strategies to reduce barriers to health care for transgender people are proposed.

Keywords: barriers to health care; transgender people; scoping review; inequality; disparities; integrated strategy; public health; empowerment; gender issues; diversity

check for updates

Citation: Costa, D. Transgender Health between Barriers: A Scoping Review and Integrated Strategies. *Societies* **2023**, *13*, 125. https://doi.org/10.3390/soc13050125

Academic Editor: Ruca Maass

Received: 1 March 2023
Revised: 10 May 2023
Accepted: 11 May 2023
Published: 14 May 2023

Copyright: © 2023 by the author. Licensee MDPI, Basel, Switzerland. This article is an open access article distributed under the terms and conditions of the Creative Commons Attribution (CC BY) license (https://creativecommons.org/licenses/by/4.0/).

1. Introduction

Transgender people have garnered attention in recent years. "Transgender" is an umbrella term that describes people whose gender identity or expression does not match the sex they have been assigned at birth (p. 1, [1]). Transgender people have different health problems; the fact, however, that they belong to a minority means that this is characterized by complex mechanisms of stigmatization. In fact, transgender people have health problems related to the delivery of health services [2] and have also particular health concerns [3]. This is a known aspect of the field called the Minority Stress Model (MSM), which relates to theories considering factors in the community that cause stress and explains how minority groups are immoderately affected by stress due to their status in society [4]. Specifically, these are the elements that form multiple barriers to health care for transgender people, that is, factors that do not allow individuals, a group of individuals or a population and/or community to access health services and/or to achieve or improve health status [5]. All this means that transgender people experience victimization phenomena that alter their state of health.

Factors such as violence, stigma and discrimination, along with other social, political and economic issues, are able to affect the physical, mental and behavioral health of transgender people [6]. Several studies showed that, compared with the general population, transgender people suffer from more chronic diseases and experience higher rates of health issues related to HIV/AIDS, substance use, mental illness and sexual and physical violence, as well as higher prevalence and earlier onset of disabilities that can also lead to health issues [7]. In addition to poorer health outcomes, transgender people also encounter unique challenges and inequalities in the context of accessing health insurance and appropriate

care [8]. The public health and economic crises have also increased existing disparities and barriers to health care for transgender people [9]. For these reasons, considering the health of transgender people and possible barriers to health care, there is no clear distinction between the context of meeting health services and social phenomena, such as discrimination (i.e., access to employment, status, income, etc.), and how these affect health outcomes; on the other hand, there is a constant influence between all these dimensions [7,10,11].

In turn, this increases the possibility of poor health conditions for transgender people with a further increase in barriers to health care [12]. As far as barriers to health care, in general, are concerned, there are different analysis models, such as the Health Care Access Barrier (HCAB), in which there are three types of barriers: financial (concerning insurance, financial protection, economic access to care, etc.), structural (concerning the physical and social environment of health care contexts) and cognitive (relational and psychological of the individual subject) [13]. This is a model based on a macrosocial type approach, i.e., concerning systematic issues. Another model of barriers to health care has been proposed by Andersen [14], known as the behavioral model of health care use. In this model, the level of analysis is microsocial, i.e., from the point of view of a single individual whose access to health protection depends on a series of factors or determinants, such as the social dimension (occupational, scholastic, physical, social, etc.), demographic factors (age, gender, etc.) and health beliefs (behaviors, attitudes and knowledge that can impact perceptions of health and illness and their support for health services) [14].

1.1. Transgender Health and Ecological Theory of Human Development

Bronfenbrenner's ecological theory of human development [15,16] turns out to be very useful for this article. According to Bronfenbrenner's [15,16] conceptual model, human development is considered a manifold system of interactions impacted by several levels of systems. Individuals and processes are pivotal to human development; individuals are the persons and how their characteristics impact social interactions across life, while processes are the reciprocal relationship between the individuals and others, objects and symbols in their environment.

Bronfenbrenner highlights five levels where these processes occur, in particular the microsystem, mesosystem, exosystem, macrosystem and chronosystem [15,16].

The first level is the microsystem and refers to the complex relationships between an individual and their setting. In the case of transgender people, it refers to long-term care homes, hospitals and clinics, use of inclusive pronouns (language), etc. [15–18].

The mesosystem also impacts individuals directly, but is composed of the interactions which occur between two or multiple system levels. The mesosystem can be lasting, such as an ongoing relationship with a general practitioner [15,16]. Moving from a familiar community to a health care environment may include moving to a heteronormative environment [17,18].

The exosystem includes environments (informal and formal social structures) where individuals are a part of without an interaction on a regular basis. In the case of transgender people, the broader health care system, agencies of government and mass media may be considered examples of this level [17,18].

The macrosystem is the culture and/or subculture that creates patterns, activities and structures that are community-based. It is informal and implicit [15,16]. The culture that an individual inhabits can be even more powerful to the transgender experience than policies and protocols [17,18].

The chronosystem includes the historical events influencing the contexts of the other systems. Regarding transgender people, their history is based on the experience of stigmatization and exclusion in society and in a health care context. This causes cumulative negative experiences acting as causative factors that result in distrust of health care systems [15–18].

Furthermore, these systems are presented as concentric. These systems are nested and interrelated to an extent that influence flows bidirectionally [15,16].

The use of Bronfenbrenner's Ecological Model [15–18] is important to understand the health needs of transgender people that were effective in identifying potential practice changes in order to better support this people in several contexts: incorporating consistent transgender cultural competence training into one's continuing education regime, including recognizing and de-escalating conflict related to sexual orientation, positionality/critical reflection of the clinician, positive communication and relationship building [15,16]; programming inclusive services for transgender people [17,18], etc.

1.2. The Aim and the Research Questions of the Review

This review aims to analyze the current literature on the barriers to health care encountered by transgender people in the context of health services to understand the interaction between different barriers and their influence on the health of transgender people.

This review is based on the following research questions: (1) What are the main barriers to health care encountered by transgender people? (2) Is it possible to organize these barriers according to a macro-, meso- and microanalysis approach? (3) What are the main characteristics of the barriers to health care encountered by transgender people? (4) Are there significant relations between the different types of barriers?

2. Materials and Methods

2.1. Study Design

The review was realized undertaken following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses, extension for scoping reviews (PRISMA-ScR) [19], and Arksey and O'Malley's methodological framework for conducting scoping studies [20].

2.2. Search Strategy

A systematic literature search was performed using the Medline (via PubMed), Scopus and Web of Science electronic databases, with combinations of search terms, tailored to the syntax and functionality of each database. Searches were conducted from December 2022 to February 2023, with no date limitation. The search query used is detailed in Table 1.

Table 1. Databases, search strategy and number of articles extracted.

Keywords	Scopus	Web Of Science	PubMed
Transgender AND barrier * AND health *	1298	1802	1168
Transgender AND health service *	3156	3353	3934
Transgender AND accessibility AND health service *	630	85	1377
Transgender AND disparity AND health service *	565	559	667
Transgender AND health system *	1427	1688	1323

* Represents any number of characters, even zero.

Subsequentially, the grey literature was identified through specific searches using Google Scholar's search engine up to page 20 [21]. Only English-language documents were considered eligible for inclusion.

2.3. Inclusion and Exclusion Criteria

The criteria for the articles' inclusion/exclusion were decided using the modified PICOTS framework (population, interventions, comparators, outcomes, timing and setting) [22] are described in Table 2.

Table 2. Criteria for the articles' inclusion/exclusion according to a modified PICOTS.

Parameter	Inclusion Criteria	Exclusion Criteria
Source	Studies that investigated the barriers to health care for transgender people	Studies not focused on the barriers to health for transgender people
Intervention	Explores the presence of barriers classified in specific and nongeneric typologies. Explores the presence of a specific nomenclature of barriers.	Only whether barriers are mentioned in a generic way without any categorization.
Comparator	None	None
Outcomes	Provides a punctual and specific definition of the barriers in order to be able to propose a specific framework and/or any suggestions.	Models, papers or tools not focused on barriers or in any case devoid of practical effects on the health of transgender people
Timeframe	Unrestricted (final extraction: February 2023)	Unrestricted (final extraction: February 2023)
Study Type	Research articles and review articles published in peer-reviewed journals	Book chapters, book reviews, vignette studies, supplements, study protocols, commentaries, guidelines, editorials, book, meeting abstract, letter to editors
Language	English	Non-English

The parameter "Patients" was adapted to "Source", "Setting" to "Study type" and we included "Language".

2.4. Review Team

Considering that the article has only one author, it was necessary to set up a review team made up of three members. These three members participated only in the study selection and data extraction activities. As they did not participate in the other stages of writing and elaboration of the article, these members were not eligible as authors.

2.5. Study Selection

According to the inclusion and exclusion criteria, the author and the review team retrieved and independently investigated the complete texts of the screened publications and the complete list of titles generated by the search procedure, and they constructed a preliminary classification list of the articles. These articles were subjected to an abstract review, and the full texts of potentially relevant articles were obtained. The author and the review team independently assessed their eligibility for inclusion. Then, the author searched the references of the articles selected to identify other relevant studies. Any difference in opinion about the paper inclusion was solved through a discussion until the author and the review team achieved a consensus.

2.6. Data Extraction and Synthesis

From the included articles, the following data were extracted: (1) Authors, (2) Title, (3) Year, (4) Country, (5) Methods/Study design, (6) Population, (7) Study content and (8) Type of barriers. For the selected articles, the data sheets were organized in such a way to extract all data of potential relevance. The author and a member of the review team performed the filtering independently and the author ensured the accuracy of the selected, reviewed results. The extracted form contained the following elements: reference, title, journal, publication year, type of study, aim/research questions, type of barriers identified and key findings. Missing data were filled in, when possible, by email correspondence with the studies' authors. Risk of bias or methodological quality of the included

articles was not used because it was not necessary for a scoping review [13]. Results are presented narratively: a synthesis was the best choice for showing several results of the included studies.

2.7. Quality Assessment

The quality assessment was performed using AMSTAR 2: a critical appraisal tool for systematic reviews, which include randomized or nonrandomized studies of health care interventions, or both [23]. The related questionnaire is included in the supplementary material (Questionnaire S1).

3. Results

3.1. Selected Studies

A total of 1980 articles were identified, 1007 in Scopus, 602 in Web of Science, 171 in PubMed and 200 in Google Scholar. After duplicate removal (n = 382), 1598 articles remained for screening. Subsequently, through the screening phase, 1321 articles were excluded and 277 articles were assessed for eligibility. In total, 245 papers were excluded because they did not meet the inclusion criteria; thus, 32 articles were included in the review. A flow diagram providing the number of articles included and excluded at each stage is provided in Figure 1.

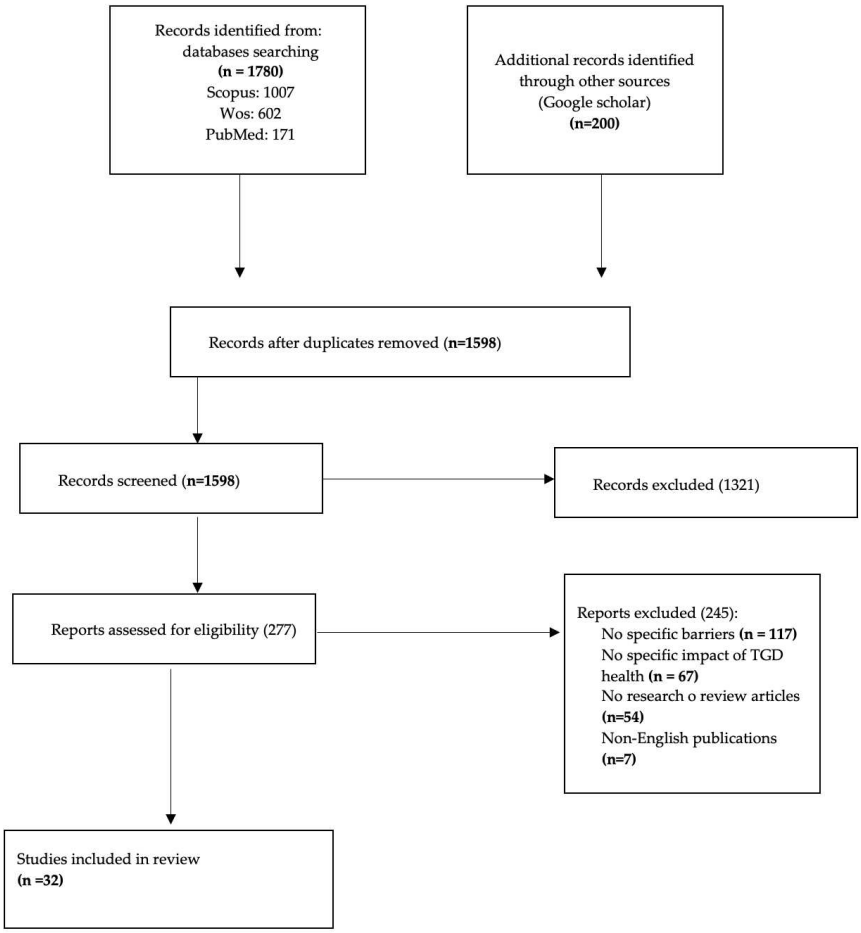

Figure 1. PRISMA-ScR 2018 flow diagram.

3.2. General Characteristics of the Included Studies

In total, 32 articles were included in this review and the general characteristics of the included studies are summarized in Table 3.

Table 3. General characteristics of the included studies.

Authors	Title	Year	Country	Methods/Study Design	Population	Study Content	Types of Barriers
1. Kurtz P.S. et al. [24]	Barriers to Health and Social Services for Street-Based Sex Workers	2005	United States	Qualitative study using an interview and focus group	Sex workers Transgender, women, etc. (n = 611)	To examine the service needs and associated barriers to access among sex workers	Structural barriers; Individual barriers
2.Chakrapani V. et al. [25]	Barriers to free antiretroviral treatment access among kothi-identified men who have sex with men and aravanis (transgender women) in Chennai, India	2011	India	Qualitative study using an interview and focus group	Kothi (n = 17)	To identify and understand barriers faced by these marginalized groups in accessing free antiretroviral treatment in government treatment centers	Family/ social-level barriers; Health care system barriers; Individual level barriers
3. Snelgrove J.W. et al. [26]	"Completely out-at-sea" with "two-gender medicine": A qualitative analysis of physician-side barriers to providing healthcare for transgender patients	2012	United States	Qualitative study using semi-structured interviews	Physician (n = 13)	To examine physician perceptions of barriers to health care provision for transgender patients	Health care barriers
4. Tanner A.E. et al. [27]	Factors influencing health care access perceptions and care-seeking behaviors of immigrant Latino sexual minority men and transgender individuals: Baseline findings from the HOLA intervention study	2014	United States	Quantitative study using a survey	Latino sexual minority men and transgender individuals (n = 180)	To examine factors associated with perceptions of access and actual care behaviors among this population in North Carolina	Macrostructural barriers; Mesostructural barriers; Microstructural barriers

Table 3. *Cont.*

Authors	Title	Year	Country	Methods/Study Design	Population	Study Content	Types of Barriers
5. Singh Y. et al. [28]	Gender Transition Services for Hijras and Other Male-to-Female Transgender People in India: Availability and Barriers to Access and Use	2014	India	Qualitative study using using a focus group, in-depth interviews and informant interviews	Hijras/ Transgender people and service providers (n = 94)	To explore access to and use of gender transition services by hijras and other male-to-female transgender people in the public and private hospitals in seven Indian cities	Systemic barriers; Community barriers; Personal barriers
6. Roberts T.K. and Fantz C.R. [29]	Barriers to quality health care for the transgender population	2014	United States	Review	NA	To explore the literature on barriers	Structural barriers; Financial barriers
7. Shaikh S. et al. [30]	Empowering communities and strengthening systems to improve transgender health: outcomes from the Pehchan programme in India	2016	India	Quantitative study using a cross-sectional survey	Transgender people (n = 268)	To strengthen community systems and provide HIV, health, legal and social services to transgender communities across 18 Indian states through a rights-based empowerment approach	Structural barriers; Social barriers
8. Safer J.D. et al. [31]	Barriers to healthcare for transgender individuals	2016	United States	Review	NA	To briefly review the literature characterizing barriers to health care for transgender individuals and to propose research priorities to understand the mechanisms of those barriers and interventions to overcome them	Direct barriers; Indirect barriers; Health care barriers; Financial barriers; Structural barriers; Social barriers.

Table 3. *Cont.*

Authors	Title	Year	Country	Methods/Study Design	Population	Study Content	Types of Barriers
9. Tagliamento G. and Paiva, V. [32]	Trans-Specific Healthcare: Challenges in the Context of New Policies for Transgender People	2016	Brazil	Qualitative study using an interview and direct participant observation	23 transgender people	To understand transgender peoples' access to the Brazilian public health care system in light of the new public policies for this group in Brazil	Programmatic barriers
10. Szydlowski M. [33]	The Rights to Health and Health Care of Vulnerable Populations: Reducing the Existing Barriers to Health Equity Experienced by Transgender People in Ireland	2016	Ireland	Review	NA	To explore the existing barriers that Irish transgender people encounter while accessing medical care and to identify potential measures to minimize their negative impact	Direct barriers; Indirect barriers
11. Vermeir E. et al. [34]	Barriers to primary and emergency healthcare for trans adults	2017	United States	Qualitative study using an interview	Adult transgender people (n = 8)	To explore the barriers trans adults encounter when pursuing primary and emergency care in Nova Scotia	Interpersonal barriers; Physical barriers; Environment barriers
12. Romanelli M. et al. [35]	Individual and systemic barriers to health care: Perspectives of lesbian, gay, bisexual, and transgender adults.	2017	United States	Qualitative study using an interview	Transgender People (40)	To explore the systematic and individual barriers to health care	Individual barriers; Systematic barriers

Table 3. *Cont.*

Authors	Title	Year	Country	Methods/Study Design	Population	Study Content	Types of Barriers
13. Gonzales G. et al. [36]	Barriers to Care Among Transgender and Gender Nonconforming Adults	2017	United Stated	Quantitative study using a survey	Transgender people (1173)	To compared barriers to care among cisgender, transgender and gender nonconforming (GNC) adults using data from a large, multistate sample	Health care barriers
14. Valenta T. et al. [37]	Experiences of transgender individuals when accessing health care: a qualitative systematic review protocol	2018	United States	Review	NA	To synthesize existing qualitative literature examining the experiences of transgender individuals when accessing health care	Structural barriers
15. Reback C.J. et al. [38]	Health Disparities, Risk Behaviors and Healthcare Utilization Among Transgender Women in Los Angeles County: A Comparison from 1998–1999 to 2015–2016	2018	United States	Quantitative study using a survey	Transgender women (n = 515)	To compare how structural determinants of health, HIV prevalence, HIV risk behaviors, substance use, gender confirmation procedures and perceived discrimination and harassment/abuse differed across a 17-year period	Structural barriers
16. Aylagas-Crespillo M. et al. [39]	Barriers to social and healthcare assistance for transgender persons: A systematic review of qualitative studies	2018	Spain	Review	NA	To explore the barriers to requesting social and health care assistance perceived by transgender persons and professionals involved in the assistance	Individual barriers; Organizational barriers; Barriers at the community level; Barriers at the political level

Table 3. *Cont.*

Authors	Title	Year	Country	Methods/Study Design	Population	Study Content	Types of Barriers
17. Philbin M.M. et al. [40]	Structural barriers to HIV prevention among men who have sex with men (MSM) in Vietnam: Diversity, stigma, and healthcare access	2018	Thailand	Qualitative study using an in-depth interview and focus group	Transgender people (n = 63)	To explore three key structural issues, i.e., diversity, stigma and access to health care services, in order to lay the groundwork for raising questions that are crucial to consider for the successful implementation of HIV prevention among transgender people in Vietnam and elsewhere in the region	Structural barriers
18. Luvuno Z.P. et al. [41]	Transgender population's experiences with regard to Accessing reproductive health care in Kwazulu-Natal, South Africa: A qualitative study	2019	Africa	Qualitative study using an interview	Transgender people (n = 9)	To examine the experiences of the transgender population in accessing health care facilities for sexual and reproductive needs	Structural barriers; Systemic barriers
19. Kcomt L. [42]	Profound health-care discrimination experienced by transgender people: rapid systematic review	2019	United States	Review	NA	To explore the prevalence of health care discrimination among transgender people in the U.S. and draw comparisons with sexual minority samples and the general U.S. population	Health care barriers

Table 3. *Cont.*

Authors	Title	Year	Country	Methods/Study Design	Population	Study Content	Types of Barriers
20. Luvuno Z.P. et al. [43]	Evidence of interventions for improving healthcare access for lesbian, gay, bisexual, and transgender people in South Africa: A scoping review	2019	Africa	Review	NA	To provide an overview of documented evidence on South African interventions aimed at improving health care access for LGBT individuals using a systematic scoping review	Structural barriers; Systemic barriers
21. Lacombe-Duncan A. et al. [44]	Gender-affirmed healthcare experiences and medical transition among transgender women living with HIV: a mixed-methods study	2019	United States	Mixed methods using a cross-sectional survey and semi-structured interview	Transgender people (n = 59)	To describe barriers and facilitators to access to medical transition among transgender people	Structural barriers; Interpersonal barriers; Institutional barriers
22. Snow A. et al. [45]	Barriers to Mental Health Care for Transgender and Gender-Nonconforming Adults: A Systematic Literature Review	2019	United States	Review	NA	To explore obstacles to transgender people mental health care	Psychotherapeutic barriers
23. Brookfield S. et al. [46]	Barriers to Accessing Sexual Health Services for Transgender and Male Sex Workers: A Systematic Qualitative Meta-summary	2020	Australia	Review	NA	To appraise and summarize the qualitative literature regarding barriers to health care for transgender people	Structural barriers
24. Watson C.W.M. et al. [47]	Barriers and facilitators to prep initiation and adherence among transgender and gender non-binary individuals in southern California	2020	United States	Qualitative study using a focus group	Transgender and nonbinary people (n = 37)	To explore pre-exposure prophylaxis awareness and identify trans-specific perceived barriers and facilitators of pre-exposure prophylaxis uptake	Structural barriers

Table 3. *Cont.*

Authors	Title	Year	Country	Methods/Study Design	Population	Study Content	Types of Barriers
25. Kcomt L. et al. [48]	Healthcare avoidance due to anticipated discrimination among transgender people: A call to create trans-affirmative environments	2020	United States	Quantitative study using a survey	Transgender people (*n*= 19,157)	To explore avoidance of health care due to anticipated discrimination among transgender adults	Interpersonal barriers; Structural barriers
26. Ziegler E. et al. [49]	Primary Care for Transgender Individuals: A Review of the Literature Reflecting a Canadian Perspective	2020	United States	Review	NA	To understand the primary-care needs and access to health care services for transgender adults in Canada	Organizational barriers
27. Bakko M. et al. [50]	Transgender-Related Insurance Denials as Barriers to Transgender Healthcare: Differences in Experience by Insurance Type.	2020	United States	Quantitative study using a survey	Transgender and nonbinary people (11,320)	To investigates the association between transgender and nonbinary individuals' experiences of different forms of transgender-related insurance denial and insurance types	Financial barriers
28. Kattari S.K. et al. [51]	Intersecting Experiences of Healthcare Denial Among Transgender and Nonbinary Patients	2020	United States	Quantitative study using a survey	Transgender people (27,715)	To explore lack of evidence on how health care denials vary by gender identity and other intersecting identity characteristics in transgender and nonbinary populations	Health care barriers; Structural barriers; Policy barriers

Table 3. *Cont.*

Authors	Title	Year	Country	Methods/Study Design	Population	Study Content	Types of Barriers
29. Kattari S.K. et al. [52]	Exploring the Experiences of Transgender and Gender Diverse Adults in Accessing a Trans Knowledgeable Primary Care Physician	2021	United States	Quantitative study using a survey	Transgender people (27,715)	To understand differences within the transgender population regarding having seen a doctor, having a primary care provider and having a primary care provider who is knowledgeable about trans health	Health care barriers; Financial barriers
30. Kattari S.K. et al. [53]	Transgender and Nonbinary Experiences of Victimization in Health care.	2021	United States	Quantitative study using a survey	Transgender and nonbinary people	To explore the experience high rates of myriad types of victimization, including in health care settings	Health care barriers
31. She R. et al. [54]	Mental health service utilisation among transgender women and sex workers who are at risk of mental health problems in Shenyang, China: An application of minority stress theory	2022	China	Quantitative study using a cross-sectional survey	Transgender people (n = 235)	To explore the factors of mental health service utilization behavior and related behavioral intention among TGSWs who were at risk of mental health problems in the past year	Internal barriers; External barriers
32. Gagnon K. et al. [55]	Qualitative inquiry into barriers and facilitators to transform primary care for lesbian, gay, bisexual, and transgender people in US federally qualified health centres	2022	United States	Cross-sectional qualitative content analysis	Service providers (n = 40)	To explore barriers and facilitators that arose during an initiative to improve care for transgender patients in federally qualified health centers from the perspectives of staff	Institutional barriers

3.3. Temporal Extension of the Included Studies

In the included set of articles of the present review, the review team found one study published in 2005, two studies were published in 2011 and 2012, while the rest of the studies were published between the years 2014 and 2020. In the period 2021-2022, the review team found two studies each. Figure 2 shows the details of the publication years of these studies.

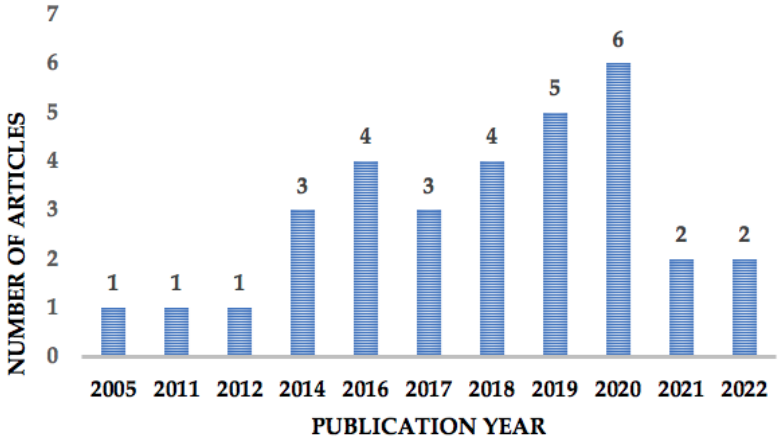

Figure 2. Publication year of the included studies.

3.4. Journal Distribution of the Included Studies and Their Research Areas

The analysis shows, as demonstrated by 32 papers published in 29 different journals, that barriers form a part of the research field of several different journals which relate to different areas: from biomedical ones to those typical of the social sciences. Regarding the research area, most of the journals are public environmental journals, occupational health journals or social science journals. Table 4 shows the journal distribution and the research areas of the included studies.

Table 4. Journal distribution and research areas of the included studies.

Name of Journal	Number of Articles	Research Areas
African journal of primary health care & family medicine	2	Good health and well-being; Goal Gender equality; Reduced Inequalities; Health Policy/legislation and jurisprudence; Health Services Accessibility; Sexual and Gender Minorities
Aids and behavior	2	Public, Environmental and Occupational Health; Biomedical Social Sciences
Aids care	1	Health Care Sciences and Services; Public, Environmental and Occupational Health; Psychology; Respiratory System; Biomedical Social Sciences
American Journal of Orthopsychiatry	1	Psychiatry; Social Work
American Journal of Preventive Medicine	1	Public, Environmental and Occupational Health; General and Internal Medicine
Aids education and prevention	1	Education and Educational Research; Public, Environmental and Occupational Health
BMC health services research	1	Health Care Sciences and Services
BMJ Open	1	Health Care Sciences and Services
Clinical biochemistry	1	Medical Laboratory Technology
Culture health & sexuality	1	Family Studies; Biomedical Social Sciences
Current Opinion in Endocrinology, Diabetes and Obesity	1	Gender and Sexuality Studies

Table 4. *Cont.*

Name of Journal	Number of Articles	Research Areas
Enfermeria clinica	1	Nursing
Health & social care in the community	1	Public, Environmental and Occupational Health; Social Work
Health & social work	1	Social Work
International Journal of Environmental Research and Public Health	1	Environmental Sciences and Ecology; Public, Environmental and Occupational Health
International journal of transgenderism	1	Sexuality and Health
JBI database of systematic reviews and implementation reports	1	Health Services Accessibility; Psychology
Journal of General Internal Medicine	1	Health Care Sciences and Services; General and Internal Medicine
Journal of health care for the poor and underserved	2	Health Services Accessibility; Sex Work; Social work; Health Care Sciences and Services; Public, Environmental and Occupational Health
Journal of homosexuality	1	Psychology; Social Sciences—Other Topics
Journal of human rights practice	1	International Relations; Government and Law
Journal of interpesonal violence	1	Criminology and Penology; Family Studies; Psychology
Journal of the international aids society	1	Immunology; Infectious Diseases
Milbank Quarterly	1	Health Care Sciences and Services
Plos one	1	Science and Technology—Other Topics
Sage Open	1	Social Sciences—Other Topics
Sexual health	1	Public, Environmental and Occupational Health; Infectious Diseases
Social science & Medicine-Population Health	1	Public, Environmental and Occupational Health
Public, Environmental & Occupational Health	1	Social Work

3.5. Geospatial Distribution of the Included Studies

A geospatial analysis of the included papers showed that 32 studies were conducted in the context of nine countries, of which the majority of the studies were conducted mainly in the United States(21 articles), followed by India(3 articles) and Africa(2 articles). Only one article was conducted in Brazil, European countries, China, etc. Figure 3 shows the details of the geospatial distribution of the papers included.

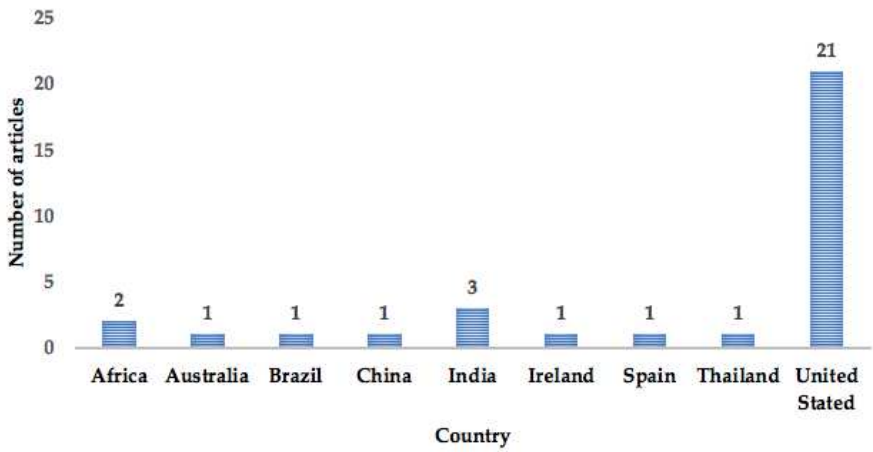

Figure 3. Geospatial distribution of papers included.

3.6. Barriers Extracted from the Included Papers

From the analysis of the articles included, different types of barriers emerged, which are reported in Table 5, and it represents the general list of barriers to health care encountered by transgender people.

Table 5. General list of barriers to health care encountered by transgender people.

Authors	Definition
1. She R. et al., 2022 [54]	***Internal barriers****concern for confidentiality; fear of discrimination; feeling that the treatment is useless; thinking that the symptoms will go away; fear of treatment.* ***External barriers****: cost concern; lack of access to qualified doctors; lack of time; negative experience of mental health services.*
2. Valenta T. et al., 2018 [37]; 3. Reback C.J. et al., 2018 [38]; 4. Philbin M.M. et al., 2018 [40]; 5. Brookfield S. et al., 2020 [46]; 6. Watson, C.W.M. et al., 2020 [47]	***Structural barriers****concern discrimination from health care providers; lack of trans-inclusive services; mental health; struggles that limit the ability to access health services and concerns about the potential side of effects of drug interactions with hormone therapy and lack of services; protection from sexually transmitted diseases.*
7. Ziegler E. et al., 2020 [49]	***Organizational barriers****concern of a lack of transgender-friendly spaces; gender-neutral spaces and toilets; gender documentation in electronic health records, and inappropriate reference ranges for laboratory systems; the lack of policies for welcoming transgender individuals and lack of training of health professionals in this regard.*
8. Luvuno Z.P. et al., 2019 [41] 9. Luvuno Z.P. et al., 2019 [43]	***Structural barriers****failure of the health care system to provide an inclusive environment, such as unisex bathrooms and appropriate arrangements for inpatient transgender patients.* ***Systemic barriers****include erasure through a failure to acknowledge the existence of the transgender population as patients within the health system. This erasure can be passive, through lack of knowledge, data, policies and practice guidelines relating to the transgender population, resulting in a paucity of programmers that cater for transgender patients; however, this erasure can also be active exclusion in the form of hostility and verbal abuse intended to cause discomfort and harm to transgender patients, thereby alienating the transgender population and, eventually, resulting in their avoidance of health care facilities.*
10. Lacombe-Duncan A. et al., 2019 [44] 11. Romanelli M. et al., 2017 [35] 12. Gagnon K. et al., 2022 [55]	***Structural access barriers****to medical transition generally described among transgender people consist of costs, lack of service availability, stigma, difficulties with the supply of drugs from female hormones to antiretroviral therapy and the lack of information on drug interactions.* ***Interpersonal barriers****: transphobia, stigma and nonacceptance.* ***Institutional barriers****: lack of knowledge about transgender health.*
13. Aylagas-Crespillo M. et al., 2017 [39]	***Individual barriers****: health status: being affected by HIV; age: youth in transgender people; perception of refusal declared by transgender people; perception of the lack of rights declared by transgender people; lack of training and skills of professionals.* ***Organizational barriers****: lack of information from transgender people about available resources; poor computerized assistance programs.* ***Community barriers****: the taboo of being transgender.* ***Barriers at the political level****: lack of legal standards, concrete policies, etc. toward the protection and safeguarding of transgender health.*

Table 5. *Cont.*

	Authors	Definition
14.	Tagliamento G. and Paiva V., 2016 [32]	***Programmatic barriers****are due to cultural standards that are difficult to modify; negative stereotypes and stigmas associated with transsexual identity, which may lead to discontinuation of ongoing clinical activity treatment. They are related to AIDS and stigmatization and discrimination of transgender people.*
15.	Szydlowski M., 2016 [33]	***Direct barriers****systematically limit access to certain services through eligibility requirements, medical necessity criteria, prohibitive costs, and restrictions on gender-specific medical services.* ***Indirect barriers,****such as stigma and discrimination, can hinder or delay the delivery of care or compromise its quality.*
16.	Shaikh S. et al., 2016 [34]	***Social barriers****: experience of high levels of both perceived and internalized social stigma, social isolation, discrimination, and victimization. Extreme social exclusion and lack of acceptance of transgender populations in different settings diminishes their self-esteem and ability to participate in social events.* ***Structural barriers****are factors that contribute to poor health and HIV risk among transgender populations. For example, medical training often excludes transgender health and, as a result, health professionals lack the appropriate skills and competencies to provide tailored services to transgender populations*
17.	Tanner A.E. et al., 2014 [27]	***Macrolevel barriers****: barriers at the health care level, distance from the nearest clinic, lack of transportation and state immigration.* ***Mesolevel barrier****: barriers at social level, availability/hours, language, time to get an appointment, too long, previous visit and high cost.* ***Microlevel barriers****: barriers at personal level, health insurance status, inability to get permission to work, lack of knowledge on where to get services, concerns about being badly treated, perception of suitability for service health and privacy issues*
18.	Singh Y. et al., 2014 [28]	***Barriers from the health system****: lack of availability of free sex reassignment surgery and hormone therapy in public hospitals; lack of experience among health professionals regarding gender transition services.* ***Policy barriers****: lack of national policy/practice guidelines for gender transition; lack of clarity on the legal status of sex reassignment surgery by qualified surgeons.* ***Community level barriers****: preference for traditional surgery among some sections of the transgender community; relative nonacceptance of surgeon-performed sex reassignment surgery (involving vagina creation) among some senior transgender gurus, as they disagree with the need for transgender identification by people with a vagina.* ***Personal Barriers****: lack of awareness among transgender people about sex reassignment surgery offered by qualified surgeons; inadequate resources to pay for gender transition services, sex reassignment surgery, breast increase and hormone therapy available in private hospitals.*
19.	Snow A. et al., 2019 [45]	***Psychotherapeutic barriers****compounded by an incongruous financial burden: having to pay to educate their therapist.*
20.	Chakrapani V. et al., 2011 [25]	***Family/social-level barriers****: lack of family support; discrimination and lack of support within other communities; unmet basic needs.* ***Health care system barriers****: negative experiences with health care providers; lack of transgender-friendly registration and admission procedures; inadequate counseling services and lack of confidentiality; perceived lack of focus on antiretroviral treatment in HIV/AIDS interventions.* ***Individual-level barriers****: delay in HIV testing; fatalism; insufficient knowledge about antiretroviral treatment and beliefs in alternative cures; alcohol use.*

Table 5. *Cont.*

Authors	Definition
21. Roberts T.K. and Fantz C.R., 2014 [29] 22. Bakko M. et al., 2020 [50] 23. Kattari S.K. et al., 2021 [52]	***Structural barriers****such as restroom access; uncomfortable with public restrooms; electronic health records, billing/coding systems and laboratory information systems have implemented a binary male/female identification system; failure to be identified by a preferred name or pronoun can cause discomfort, leading to a poor rapport with providers and impacting quality of care.* ***Financial barriers****: insurance issues; disproportionate levels of unemployment within the trans community; individual insurance market, trans identity has long been considered a preexisting condition disqualifying trans persons for coverage; "transition-related care" is excluded by insurance companies.*
24. Snelgrove J.W. et al., 2012 [26] 25. Gonzales G. et al., 2017 [35] 26. Kcomt L., 2019 [42]	***Health care barriers****are grouped into five themes: accessing resources, medical knowledge deficits, ethics of transition-related medical care, diagnosing* vs. *pathologizing trans patients and health system determinants.*
27. Vermeir E. et al., 2017 [34]	***Interpersonal barriers****: health care providers with low knowledge and health care providers and their low sensitivity and appropriateness attitudes.* ***Physical environment barriers,****such as a lack of gender-neutral washrooms; exclusion of trans-related information in health care settings; feeling that the physical environment within the health care setting was not conducive to privacy; feeling uncomfortable when filling out gender-binary medical forms and identifying these forms as a physical barrier to care.* ***Social environmental barriers****: ignoring or being blind to trans identity; barriers to pursuing hormone replacement therapy and mental health care; lack of trans-friendly clinics and resources and incessant experiences of 'discrimination' throughout that are simply untrue; fallacious social discourses incorporated into the social environments of health care settings.*
28. Kurtz P.S. et al., 2005 [24] 29. Kcomt L. et al., 2020 [48]	***Structural barriers****: availability, information, accessibility; transportation; legal status requirements; social stigma, program staff communication skills; program target population; program structure.* ***Individual barriers****: awareness of service, drug seeking and use, street life, distractions/sense of time, mental/emotional stability, fear of arrest, generalized fear, negative attitude, low frustration and tolerance.*
30. Safer J.D. et al., 2016 [31]	***Financial barriers****: lack of insurance and lack of income);* ***Health care barriers****: discrimination, lack of cultural competence by health care providers;* ***Structural barriers****: inappropriate electronic records, forms, lab references and clinic facilities; social barriers: transportation, housing and mental health;* ***Direct barriers****: lack of insurance coverage along with those that are indirect, such as unfriendly office environments and perceived stigma for both the patients themselves and the providers of transgender health care;* ***Indirect barriers****: environment and stigma.*
31. Kattari S.K. et al., 2020 [51] 32. Kattari et al., 2021 [53]	***Social barriers:*** *forms of victimization, such as 1) the doctor/health care provider used harsh or abusive language, 2) the doctor/health care provider was physically rough or abusive, 3) the patient was verbally harassed in the health care setting and 4) patient experienced unwanted sexual contact in a health care setting;* ***Policy barriers****: lack of policy protections against denial of transgender patients;* ***Health care barriers:****transphobic discrimination results in elevated rates of denial of care, receipt of substandard care (e.g., rough exams); forced care (e.g., being forced to undergo procedures);* ***Structural barriers****: lack of legal documentation discourages transgender patients from seeking appropriate and adequate care.*

For a better understanding of the findings as presented in the previous sections, the barriers were organized according to the macro-, meso-, and microlevels of social analysis [56].

3.7. Macrolevel: Health System Barriers

The barriers to health care encountered by transgender people concern the health system. *Health system barriers* have been studied by 11 papers [25–28,31,36,41–43,52,53]. They are denominated in various ways: *systemic barriers* [42,44], *macrolevel barriers* [27], *barriers to the health system* [28], *health care system barriers* [25] and *health care barriers* [26,31,36,42,52,53]. Through a synthesis of these studies, it is possible to define health system barriers as the failure to acknowledge the existence of transgender people as patients within the health system [41–43]. An important aspect of these types of barriers regards the victimization and health care setting, such as denial of services, misgendering, verbal abuse, etc. [52,53]. This type of barrier includes some *subcategories of barriers*, such as *institutional barriers*, defined as lack of knowledge about transgender health [35,44,55], *psychotherapeutic barriers*, compounded by an incongruous financial burden, i.e., having to pay to educate their therapist [46], and *structural barriers*, which will be analyzed in detail later, as they are among the most studied barriers in the included papers [24,29–31,34,35,37–41,43,44,46–53,55]. Health system barriers, according to the included studies, are influenced by other types of barriers, i.e., *policy barriers*, which allow a lack of national policy/practice guidelines for gender transition and a lack of clarity on the legal status of sex reassignment surgery by qualified surgeons [28,51,53], *barriers at the political level*, such as a lack of legal standards, concrete policies, etc. on the protection and safeguarding of transgender health [41] and *financial barriers*, that is, insurance issues, disproportionate level of unemployment within the transgender community and an individual insurance market, as transgender identity has long been considered a preexisting condition disqualifying transgender people for coverage; it is all too easy for insurance companies to exclude "transition-related care" [29,31,50,52]. These are considered *direct barriers* that systematically limit access to certain services through eligibility requirements, medical necessity criteria, prohibitive costs and restrictions on gender-specific medical services [31,33].

Structural Barriers

Structural barriers have been studied by 22 papers [24,29–31,34,35,37–41,43,44,46–53,55]. Through a synthesis of these studies, it is possible to define structural barriers, as all those obstacles to accessing different types of health services causing poor health among transgender people [29,50,52]. Structural barriers can also be referred to as *organizational barriers* [39,49] or *physical environment barriers* [34]. These types of barriers concern aspects closely related to health care spaces, such as lack of gender-neutral bathrooms and toilets [41,43,49,51,53] and binary systems of documentation in electronic health records [30,51,53]. Additionally, these types of barriers concerns a lack of training of health professionals on the health needs of transgender people [46–53,55].

3.8. Mesolevel: Social Barriers

The *social barriers* faced by transgender people are analyzed in seven studies [25,27,28,32,39,51,53]; they can be defined as experiences *with a high level of both perceived and internalized social stigma, social isolation, discrimination and victimization* [30]. Social barriers can also be referred to as *community barriers* [39], *community level barriers* [28] and *mesolevel barriers* [27]. Within the social barriers, it was possible to detect the following *subcategories*: *programmatic barriers*, which are due to cultural standards that are difficult to modify, negative stereotypes and stigmas associated with transsexual identity, which may lead to discontinuation of ongoing clinical activity treatment. They are also related to AIDS and stigmatization and discrimination of transgender people [32]. *Family/social-level barriers* consist of a lack of family support, discrimination and lack of support within other communities, unmet basic needs, etc. [25], while *interpersonal barriers* are health care providers with low knowledge and low sensitivity and appropriateness, attitudes, transphobia, nonacceptance and stigma [34,35,44,55]. These barriers are related to intersecting marginalized identities, for example, low socioeconomic status, and with forms of victimization, such as (1) the doctor/health care provider used harsh or abusive language, (2) the doctor/health

care provider was physically rough or abusive, (3) the patient was verbally harassed in the health care setting and (4) patient experienced unwanted sexual contact in a health care setting [52,54].

The *subcategory of social barriers* is *social environmental barriers* and consists of ignoring or being blind to transgender identity, barriers to pursuing hormone replacement therapy and mental health care, a lack of trans-friendly clinics and resources and incessant experiences of 'discrimination' throughout that are simply untrue and fallacious social discourses incorporated into the social environments of health care settings [34]. However, these latter barriers arise from the overlap between elements of social barriers and elements of structural barriers.

3.9. Microlevel: Individual Barriers

Individual barriers were analyzed by seven papers [24,25,27,28,34–36,39]. They are divided into *individual barriers* [24,35,39], *microlevel barriers* [27] and *personal barriers* [28]. In general, they are defined as the barriers perceived by individual transgender people [24,25,27,28,34–36,39]. Two *subcategories* have been identified within the individual barriers: *internal barriers*, concern for confidentiality, fear of discrimination, feeling that the treatment is useless, thinking that the symptoms will go away, fear of treatment, etc. [55] and *external barriers*, such as cost concerns, lack of access to qualified doctors, lack of time, negative experience of mental health services, etc. [55].

Furthermore, many of the social and individual barriers are also defined as *indirect barriers*, i.e., stigma and discrimination, because they can hinder or delay the delivery of care or compromise its quality [31,33].

3.10. The Point of View from Which the Barriers Were Detected

Regarding the point of view from which the barriers encountered by transgender people were detected, from the analysis of the 22 research articles included out of 32 total studies, 19 papers found barriers from the point of view of transgender people and only 3 studies found barriers from the point of view of health providers.

3.11. The Methods and the Research Instruments Used to Study the Barriers

Of the 32 articles included, 22 are research articles. Most of the articles included (11) have used qualitative approaches to analyze the barriers encountered by transgender people, 10 studies have used quantitative approaches and 1 has used mixed methods. The data collection instruments used in the paper included interviews (10), focus groups (5), surveys (7), participant observations (1) and content analysis (1).

4. Discussion

This study included a scoping review in order to identify the barriers to health care faced by transgender people in the context of health services. Due to the complexity of the results, the discussion was divided into subsections.

4.1. Barriers to Health Care: An Overview

The findings show the complexity of the health status of transgender people. The health needs of transgender people concern medical (e.g., hormone therapy) and socio-psychological (e.g., mental health care) interventions [57]. This review clearly highlights the stigma as barriers at all levels (macro, meso and micro) are very dangerous to the health of transgender people. Therefore, the various barriers encountered are an expression of a society that is still dominated by the stigma towards transgender people, which is reflected by the individual to the systemic dimension of the health system [58]. Moreover, the various barriers identified can be summarized by three needs: (1) lack of training on transgender people starting from health providers up to health professionals [24,28,51,53,54], (2) relational and organizational difficulties in accessing health care (e.g., access to the costs of surgical and hormonal therapy) [39–43] and (3) physical spaces (bathrooms, filing systems,

etc.) and social spaces (individual, parental and professional relationships) [48,49,52,53] still with prejudices and stereotypes regarding transgender people [20–24]. The results highlighted the need to introduce training courses for health professionals, health professionals, policy makers, etc. specific to the health of transgender people. Thus, the needs of transgender people, their health, like everyone else's, depends on who the people are (individual characteristics) and where they live (community characteristics) [59]. Thus, more inclusiveness is needed from the macrolevel to the microlevel. Inclusivity consists of the use of gender-affirming language, attitudes, etc. [60]. The consolidated presence of barriers to health care for transgender people is clear proof of the necessity to talk about specific social determinants of health (SDHs) for these people [61]. While in the past, gender inequality was referred to as SDHs of cisgender women, recently, gender SDHs have been applied to the identity and health of transgender people [62,63].

4.2. The Relationships between the Different Levels of Barriers and Their Health Implications

According to the model proposed by Bronfenbrenner [15,16], it is possible to detect a series of interactions between the different types of barriers identified.

Considering the dimensions of the individual barriers from a microsocial perspective, the individual ones highlighted in this article would require an intersectional approach that encompasses multiple aspects, i.e., physical, biological, demographic and socially constructed identities that an individual claims or that are attributed to them by others. These identities may include, for example, age, gender identity, culture/ethnic identity, racial identity, sexual identity, ability status, class, national origin and religion or spiritual background affiliation. This set of identities affects the way people present themselves or the way they are regarded by others, which in turn affects how a person interacts with the wider network of systems. The results of this review concerning barriers at the individual level are very much similar to the study by Kidd et al. [64], in which transgender people consider themselves ill-suited to different contexts, feeling outcasts in general due to their gender identity and within the transgender community due to health issues. It is important to remember that the experience of suffering from a disease, for transgender people, is shaped by a history of psychiatrists confusing gender dysphoria as a symptom of schizophrenia [65], effectively invalidating and pathologizing transgender people. All of this has a number of implications for individual health. This review suggests that health professionals should know the influence of the different sociocultural identities of the single transgender person as tools of resilience and/or as stressors, based on the needs of the individual transgender person. To do this, all health professionals should have a thorough education of the theory of intersectionality [66,67]. This is an example of interaction between different barriers.

At the mesosocial level, the barriers identified present a series of typifying characteristics, and are also interrelated with both the micro- and macrosocial ones. Therefore, the mesolevel is composed of organizations such as workplaces, school systems, law enforcement, mental and physical health systems and other general community associations. For transgender people, interacting with community systems presents unique welfare risks due to the sheer amount of transphobia that permeates these systems. The different papers included in this review demonstrated how at this level there is gender-based violence, harassment and discrimination experienced by transgender individuals in community systems. The negative effects of discrimination by society systems have also been shown to impact the well-being of cisgender people in relationships with transgender partners, with consequences on the health status of transgender people. In this case, the implications in terms of health status are indeed transversal between macro-, meso- and microdimensions, since the health implications concern both the individual transgender people as well as couples and families with transgender members. Therefore, being aware of barriers at the mesolevel can help expand inclusive communities organizations, some local and some national, provide legal services, physical health care services and transition-related services [68].

Finally, as regards the barriers to health care at the macrosocial level, the health systems are the most responsible. In fact, lack of knowledge or rejection of transition-related health services, unnecessarily invasive questions, having to educate health care professionals, verbal harassment and physical and sexual violence constitute the most critical barriers to maintain health. Moreover, completing hormonal and/or surgical transition puts transgender people in dangerous situations. These aspects are identified above all at the structural level: bathrooms, bedrooms, exclusively cisgender symbols, etc. Experiences of discrimination in health care settings operate as one of the many barriers for transgender individuals hoping to access health services. Other barriers to health care for transgender people include ill-trained health care workers, institutional cisnormativity in medical/medical record systems facilities and financial hurdles, such as limited insurance coverage and lack of income. It should be highlighted that the barriers mentioned also act at the working level, thus determining greater economic instability and a reduction in access to health insurance.

This is another example of the health care barriers of transgender individuals, which can lead to health inequalities for transgender people. Thus, the interconnectedness of these barriers to health care explains why those in the transgender community report low levels of health care use, including prevention services [69], general medical services [70] and transition services.

All these barriers often cause the search for alternative pathways for the affirmation of one's gender. These pathways concern the use of loopholes in transition insurance policies procedures [71], access to hormones for transition through illegal trade [72] and self-performed surgeries or surgeries performed by unauthorized personnel [73].

A brief reflection on the relationships between the different levels of barriers identified in this article concerns how the other levels of barriers influence the microlevel of analysis on searching and obtaining help (or not) from health care services and health care professionals. In this regard, the results obtained are in line with the fact that transgender people, even in health care contexts, encounter transphobia which consists of a set of ideas and phenomena that encompass a range of negative attitudes, feelings or actions towards transgender people or transness in general [74]. This makes transgender people more vulnerable to marginalization both in terms of access to care and in health care settings [75]. Thus, the effects on the microsetting level make that transgender people are also victims of forms of microaggressions, or common everyday verbal, behavioral or environmental insults, intentional or unintentional, which communicate hostile, derogatory or negative attitudes towards stigmatized or culturally marginalized groups. One of the most common forms of microaggressions experienced by transgender people, also in health systems, is "misgendering" (i.e., referring to a person using an incorrect pronoun/name) [75]. Thus, stigma, which transversally affects all the identified barriers, is a negative health issue for these people both because it causes stress in relating to others and because it acts as a real barrier to health [76]. Stigma also acts as a significant factor in increasing the incidence and prevalence of anxiety, depression, suicidal ideation and suicide [77]. This results in negative health care provider interactions and can also include providers not understanding the health care needs of transgender individuals, or the difference between sex, gender and sexual orientation, which can lead to providers pathologizing their patients and denying care, and negative experiences with health care may correlate with reduced quality of life and higher rates of self-reported disability among transgender people [78].

Thus, the three levels of barriers mean that health systems, personnel and places have a different structure, since all personnel, health professionals and care environments can play a role in identifying the health care needs of transgender people [79]. Health care is considered transgender-friendly when it respectfully supports the self-identified gender identity of transgender people. Breaking down barriers, starting with the microsetting, resulted in positive experiences in receiving health care when providers used inclusive and respectful language and allowed their patients more control over their own proce-

dures [80]. Health care that protects and respects transgender people can significantly improve transgender people health [81].

4.3. Countries of Included Studies

A brief consideration concerns the countries in which the studies included in this review were conducted. In total, 21 were conducted in the United States, where access to care depends on insurance. In fact, in the United States, transgender people are denied coverage for treatments specific to their gender needs, such as screening services, hormone therapy, etc.; this is because insurers consider these interventions unnecessary or unsuitable [59]. Three studies were conducted in India and two in Africa, where the degree of stigmatization and nonacceptance of transgender people is still very high [82,83].

Since 21 studies included in this review were conducted in the United States, most of the considerations related to the identified barriers, public health aspects and recommendations are related to the American cultural context, in which the number of transgender people out of the general adult population it is about 1.6%, while in young people the number comes close to 5.1% [84], and therefore, there is a growing interest in the study of health and the health barriers encountered by transgender people in the US.

4.4. Barriers, Transgender People and Public Health

The results obtained from this review confirm the need for greater equity towards transgender people. In this context, public health research goes toward policies that can protect and promote transgender health. Several barriers are related to the fragmentary nature of nondiscrimination laws across work, education, housing, public health rights, etc. [85]. Considering SDHs, and all issues related to gender identity should be included in social movements for health equity, civil rights and health reform. The prevalence of poverty among some transgender groups affects significatively the well-being of transgender people [86]. In this regard, although the World Health Organization (WHO) in their program includes the aim that more than one billion people will have universal health access, including transgender people, the actual outcomes of the included studies underline that several transgender people still encounter health barriers and related problems [87–89]. Research on barriers to the health of transgender people are growing; however, to improve transgender health care, more culturally and specific operational training is needed. Health systems should consider several existing flaws to ensure inclusiveness of care to transgender people and improve the related transformations. The lack of appropriate training and knowledge of health care professionals should be highlighted. An adequate and important institutional intervention for training and professional development is essential in this context in order to implement routine medical care to transgender people and to assure that health services could be provided in a nonstigmatizing, nondiscriminatory and informed setting [90,91]. Therefore, the results obtained underline the need to increase the empowerment of transgender people, in order to improve their quality of life, i.e., it is pivotal to improve information, training and specific processes, using appropriate tools and promoting active involvement in decisions related to the health of transgender people [92]. The existence of barriers to health care could be eliminated by resorting to the concept of empowerment, because transgender people would achieve appropriate control and protection over their lifestyle and activities that are important for their quality of life. Empowerment would be a tool for prevention and training [93]. The presence of barriers to health care may also underline the need for more effective civic participation of transgender people, an issue that would implement social integration, economic progress and formal acceptance of their psychosocial and even legal equality. It can immeasurably support their empowerment and act as an acknowledgment of their human dignity and change the way they are perceived by several individuals in society, such as family, police, government actors and health care personnel, that are encountered in their daily lives [94,95].

4.5. Strengths and Limitations of the Research

This paper has strengths and limitations. The first limitation is represented by having excluded papers not in English, which has led to a probable loss of information. A strong point, however, is that the search strategy was complete, having been carried out on the three main databases. Another strength is the use of the PICOTS method to identify the inclusion and exclusion criteria. The studies, independently of the methods used, were included to jointly present the findings, which may also be considered a limitation. This study did not include the analysis of nonbinary, gender-fluid and other gender-diverse terms for the difficulty to link these heterogeneous terms to health barriers and their specific denominations. Moreover, for the same reasons, in the search strategy, terms such as two-spirited, brotherboy, sistergirl, hijra, fa'afafine and others were not included. This represents a limitation of this study. Another limitation regards that the following databases CINAHL and PsychInfo databases were not used, as they were not accessible at the author's institution. The design of the study does not allow to explore specific issues on health personal's competence and attitude to treat transgender people as treatments used in transgender health care are very different all over the world, also because of the heterogeneity in the current literature. Possibly, further research subdivided per world region may help to achieve this goal. However, this review aimed to summarize the scientific evidence regarding the barriers to health equity for transgender people; therefore, all identified articles were included to facilitate the overview of the key factors influencing the health status of transgender people.

5. Conclusions

This study updated the main barriers to health care faced by transgender people, from which a tripartition of these barriers emerged. Due to the complexity of gender problems and health barriers, a multidisciplinary and complex approach [96] is necessary, capable of grasping all critical issues that health needs, and the barriers connected to them, that transgender people encounter during their lives.

The evidence and arguments presented address a specific gap in the field as well as the main questions posed. In this regard, Figure 4 summarizes a series of integrated strategies to reduce barriers to health care for transgender people.

Figure 4 on the left shows the main stakeholders that should be involved in managing and reducing barriers. At the center, there are the health system, social and individual barriers. Between stakeholder and barrier types, there are a number of relationships indicated with double-headed arrows to indicate the mutual influence between all these dimensions. Some proposed strategies are shown on the right. Clearly, the list is not exhaustive, but it is only a starting point for possible extensions. The main element of these strategies is multidisciplinary and the integration of knowledge and skills, emphasizing the role of the social sciences, which, on issues of gender, stigma, nondiscrimination, etc., constitute training and information tools at any level of activity in favor of transgender people. Strategies and barriers have been considered in mutual relationships and influence, being considered in an integrated perspective.

Further research on this topic is needed in order to provide more awareness and insight into the realities of the lives of these people, as well as the social taboos and stigma surrounding their lives. In this way, the aforementioned problems need to be eliminated in the near future in order to ensure transgender people are accepted by their families and in general by society, just like other citizens.

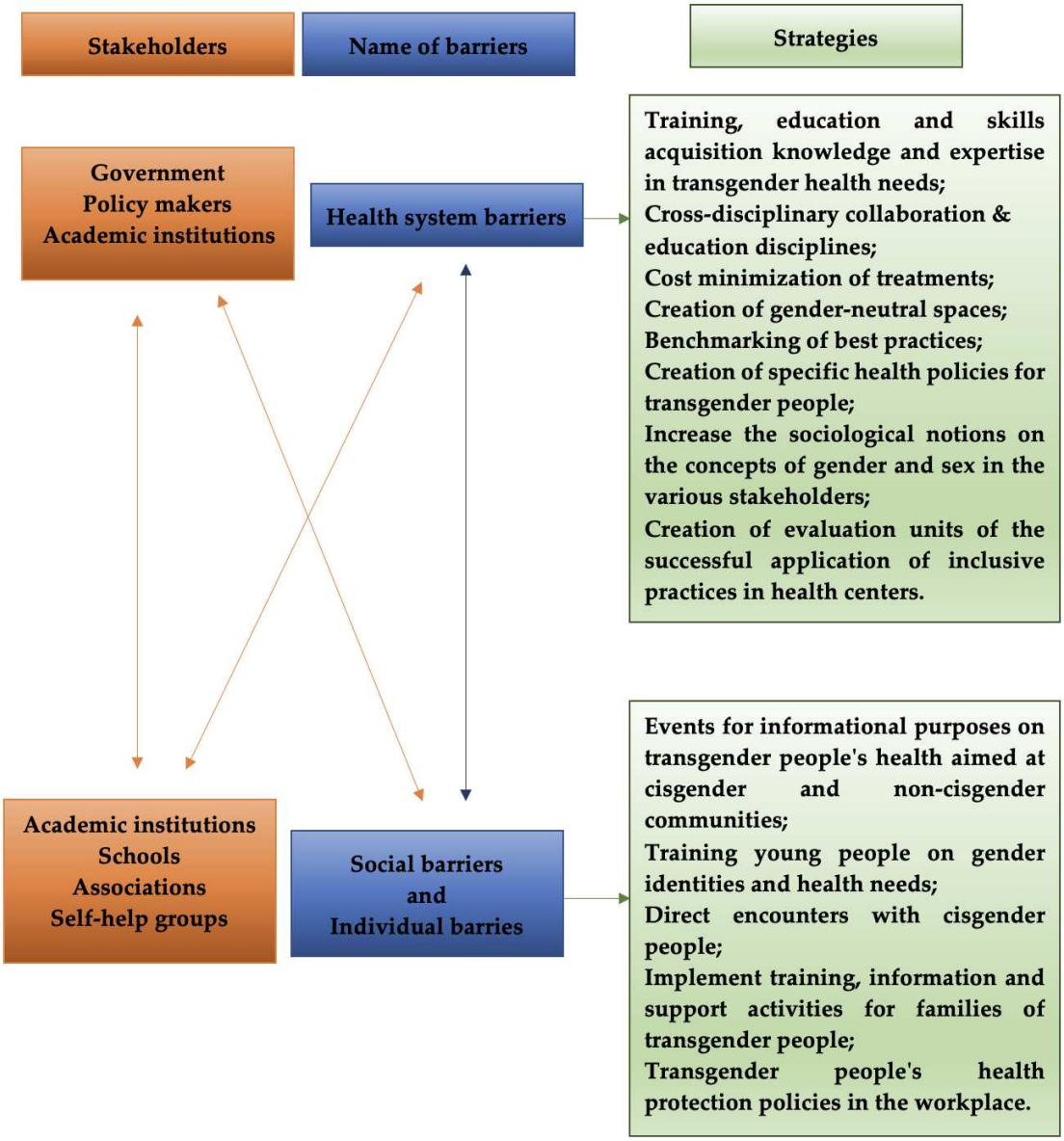

Figure 4. Integrated strategies to reduce barriers to health care for transgender people.

Supplementary Materials: The following supporting information can be downloaded at: https://www.mdpi.com/article/10.3390/soc13050125/s1, Questionnaire S1 quality assessment performed using AMSTAR 2.

Funding: This research received no external funding.

Institutional Review Board Statement: Not applicable.

Informed Consent Statement: Not applicable.

Data Availability Statement: All data generated or analyzed during this study are included in this published article.

Acknowledgments: I thank the members of the review team who contributed in the activities of study selection and data extraction. In particular, I thank: Francesca Gentile (Nurse), Jessica Maria Marcella (Sociologist and Criminologist) and Alessia Yvonne Mancuso (Sociologist and Pedagogist).

Conflicts of Interest: The author declares no conflict of interest.

References

1. Baqutayan, S.M.; Mahdzir, A.M.; Yusof, N.A.M.; Saimy, I.S.; Salleh, S.H. Public opinions and gender issue. *Eur. Rev. Med. Pharmacol. Sci.* **2021**, *25*, 5215–5227. [PubMed]
2. Meyer, I.H.; Northridge, M.E. *The Health of Sexual Minorities: Public Health Perspectives on Lesbian, Gay, Bisexual and Transgender Populations*; Springer Science & Business Media: Berlin/Heidelberg, Germany, 2007.
3. Costa, D. The influence of social capital on health issues among transgender and gender diverse people: A rapid review. *Sci. Philos.* **2022**, *10*, 109–131.
4. Meyer, I.H. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychol. Bull.* **2003**, *129*, 674–697. [CrossRef] [PubMed]
5. HWB. Unit 1—Health, Social Services and Children Services; Access and Barriers, United Kingdom, ND. Available online: http://resources.hwb.wales.gov.uk/VTC/2012-13/22032013/hsc/eng/unit_1/u1-a-and-b/u1-a-and-b1.htm (accessed on 1 February 2023).
6. Bockting, W.O.; Miner, M.H.; Swinburne Romine, R.E.; Hamilton, A.; Coleman, E. Stigma, mental health, and resilience in an online sample of the US transgender population. *Am. J. Public Health* **2013**, *103*, 943–951. [CrossRef]
7. Reisner, S.L.; Poteat, T.; Keatley, J.; Cabral, M.; Mothopeng, T.; Dunham, E.; Baral, S.D. Global health burden and needs of transgender populations: A review. *Lancet* **2016**, *388*, 412–436. [CrossRef]
8. Stroumsa, D. The state of transgender health care: Policy, law, and medical frameworks. *Am. J. Public Health* **2014**, *104*, e31–e38. [CrossRef]
9. Douthit, N.; Kiv, S.; Dwolatzky, T.; Biswas, S. Exposing some important barriers to health care access in the rural USA. *Public Health* **2015**, *129*, 611–620. [CrossRef] [PubMed]
10. Snelgrove, J.W.; Jasudavisius, A.M.; Rowe, B.W.; Head, E.M.; Bauer, G.R. "Completely out-at-sea" with "two-gender medicine": A qualitative analysis of physician-side barriers to providing healthcare for transgender patients. *BMC Health Serv. Res.* **2012**, *12*, 1–13. [CrossRef]
11. Byne, W.; Karasic, D.H.; Coleman, E.; Eyler, A.E.; Kidd, J.D.; Meyer-Bahlburg, H.F.; Pula, J. Gender dysphoria in adults: An overview and primer for psychiatrists. *Transgender Health* **2018**, *3*, 57-A3. [CrossRef] [PubMed]
12. Messinger, A.M.; Guadalupe-Diaz, X.L.; Kurdyla, V. Transgender Polyvictimization in the U.S. Transgender Survey. *J. Interpers. Violence* **2022**, *37*, NP18810–NP18836. [CrossRef]
13. Carrillo, J.E.; Carrillo, V.A.; Perez, H.R.; Salas-Lopez, D.; Natale-Pereira, A.; Byron, A.T. Defining and targeting health care access barriers. *J. Health Care Poor Underserved* **2011**, *22*, 562–575. [CrossRef]
14. Andersen, R.M. Revisiting the behavioral model and access to medical care: Does it matter? *J. Health Soc Behav.* **1995**, *36*, 1–10. [CrossRef] [PubMed]
15. Bronfenbrenner, U. *The Ecology of Human Development: Experiments by Nature and Design*; Harvard University Press: Cambridge, MA, USA, 1979.
16. Bronfenbrenner, U. Ecology of the family as a context for human development: Research perspectives. *Dev. Psychol* **1986**, *22*, 723–742. [CrossRef]
17. Lintott, L.; Beringer, R.; Do, A.; Daudt, H. A rapid review of end-of-life needs in the LGBTQ+ community and recommendations for clinicians. *Palliat. Med.* **2022**, *36*, 609–624. [CrossRef]
18. Edwards, L.; Goodwin, A.; Neumann, M. An ecological framework for transgender inclusive family therapy. *Contemp. Fam. Ther.* **2019**, *41*, 258–274. [CrossRef]
19. Tricco, A.C.; Lillie, E.; Zarin, W.; O'Brien, K.K.; Colquhoun, H.; Levac, D.; Moher, D.; Peters, M.D.J.; Horsley, T.; Weeks, L.; et al. PRISMA Extension for Scoping Reviews (PRISMA-ScR): Checklist and Explanation. *Ann. Intern. Med.* **2018**, *169*, 467–473. [CrossRef] [PubMed]
20. Arksey, H.; O'Malley, L. Scoping studies: Towards a methodological framework. *Int. J. Soc. Res. Methodol.* **2005**, *8*, 19–32. [CrossRef]
21. Haddaway, N.R.; Collins, A.M.; Coughlin, D.; Kirk, S. The Role of Google Scholar in Evidence Reviews and Its Applicability to Grey Literature Searching. *PLoS ONE* **2015**, *10*, e0138237. [CrossRef]
22. Samson, D.; Schoelles, K.M. Medical tests guidance (2) developing the topic and structuring systematic reviews of medical tests: Utility of PICOTS, analytic frameworks, decision trees, and other frameworks. *J. Gen. Intern. Med.* **2012**, *27*, 11–19. [CrossRef] [PubMed]
23. Shea, B.J.; Reeves, B.C.; Wells, G.; Thuku, M.; Hamel, C.; Moran, J.; Moher, D.; Tugwell, P.; Welch, V.; Kristjansson, E.; et al. AMSTAR 2: A critical appraisal tool for systematic reviews that include randomised or non-randomised studies of healthcare interventions, or both. *BMJ (Clin. Res. Ed.)* **2017**, *358*, j4008. [CrossRef] [PubMed]
24. Kurtz, S.P.; Surratt, H.L.; Kiley, M.C.; Inciardi, J.A. Barriers to health and social services for street-based sex workers. *J. Health Care Poor Underserved* **2005**, *16*, 345–361. [CrossRef] [PubMed]
25. Chakrapani, V.; Newman, P.A.; Shunmugam, M.; Dubrow, R. Barriers to free antiretroviral treatment access among kothi-identified men who have sex with men and aravanis (transgender women) in Chennai, India. *AIDS Care* **2011**, *23*, 1687–1694. [CrossRef] [PubMed]
26. Ziegler, E.; Valaitis, R.; Yost, J.; Carter, N.; Risdon, C. Primary care is primary care: Use of Normalization Process Theory to explore the implementation of primary care services for transgender individuals in Ontario. *PLoS ONE* **2019**, *14*, e0215873. [PubMed]

27. Tanner, A.E.; Reboussin, B.A.; Mann, L.; Ma, A.; Song, E.; Alonzo, J.; Rhodes, S.D. Factors influencing health care access perceptions and care-seeking behaviors of immigrant Latino sexual minority men and transgender individuals: Baseline findings from the HOLA intervention study. *J. Health Care Poor Underserved* **2014**, *25*, 1679. [CrossRef] [PubMed]
28. Singh, Y.; Aher, A.; Shaikh, S.; Mehta, S.; Robertson, J.; Chakrapani, V. Gender transition services for Hijras and other male-to-female transgender people in India: Availability and barriers to access and use. *Int. J. Transgenderism* **2014**, *15*, 1–15. [CrossRef]
29. Roberts, T.K.; Fantz, C.R. Barriers to quality health care for the transgender population. *Clin. Biochem.* **2014**, *47*, 983–987. [CrossRef]
30. Shaikh, S.; Mburu, G.; Arumugam, V.; Mattipalli, N.; Aher, A.; Mehta, S.; Robertson, J. Empowering communities and strengthening systems to improve transgender health: Outcomes from the Pehchan programme in India. *J. Int. AIDS Soc.* **2016**, *19*, 20809. [CrossRef]
31. Safer, J.D.; Coleman, E.; Feldman, J.; Garofalo, R.; Hembree, W.; Radix, A.; Sevelius, J. Barriers to healthcare for transgender individuals. *Curr. Opin. Endocrinol. Diabetes Obes.* **2016**, *23*, 168–171. [CrossRef]
32. Tagliamento, G.; Paiva, V. Trans-specific health care: Challenges in the context of new policies for transgender people. *J. Homosex.* **2016**, *63*, 1556–1572. [CrossRef]
33. Szydlowski, M. The rights to health and health care of vulnerable populations: Reducing the existing barriers to health equity experienced by transgender people in Ireland. *J. Hum. Rights Pract.* **2016**, *8*, 239–263. [CrossRef]
34. Vermeir, E.; Jackson, L.A.; Marshall, E.G. Barriers to primary and emergency healthcare for trans adults. *Cult. Health Sex.* **2018**, *20*, 232–246. [CrossRef]
35. Romanelli, M.; Hudson, K.D. Individual and systemic barriers to health care: Perspectives of lesbian, gay, bisexual, and transgender adults. *Am. J. Orthopsychiatry* **2017**, *87*, 714–728. [CrossRef] [PubMed]
36. Gonzales, G.; Henning-Smith, C. Barriers to Care Among Transgender and Gender Nonconforming Adults. *Milbank Q.* **2017**, *95*, 726–748. [CrossRef]
37. Valenta, T.; Shade, K.; Lieggi, M. Experiences of transgender individuals when accessing health care: A qualitative systematic review protocol. *JBI Evid. Synth.* **2018**, *16*, 628–634. [CrossRef]
38. Reback, C.J.; Clark, K.; Holloway, I.W.; Fletcher, J.B. Health disparities, risk behaviors and healthcare utilization among transgender women in Los Angeles County: A comparison from 1998–1999 to 2015–2016. *AIDS Behav.* **2018**, *22*, 2524–2533. [CrossRef] [PubMed]
39. Aylagas-Crespillo, M.; García-Barbero, Ó.; Rodríguez-Martín, B. Barriers in the social and healthcare assistance for transgender persons: A systematic review of qualitative studies. *Enfermería Clínica (Engl. Ed.)* **2018**, *28*, 247–259. [CrossRef]
40. Philbin, M.M.; Hirsch, J.S.; Wilson, P.A.; Ly, A.T.; Giang, L.M.; Parker, R.G. Structural barriers to HIV prevention among men who have sex with men (MSM) in Vietnam: Diversity, stigma, and healthcare access. *PLoS ONE* **2018**, *13*, e0195000. [CrossRef] [PubMed]
41. Luvuno, Z.P.; Ncama, B.; Mchunu, G. Transgender population's experiences with regard to accessing reproductive health care in Kwazulu-Natal, South Africa: A qualitative study. *Afr. J. Prim. Health Care Fam. Med.* **2019**, *11*, 1–9. [CrossRef]
42. Kcomt, L. Profound health-care discrimination experienced by transgender people: Rapid systematic review. *Soc. Work. Health Care* **2019**, *58*, 201–219. [CrossRef]
43. Luvuno, Z.P.; Mchunu, G.; Ngidi, H.; Ncama, B.; Mashamba-Thompson, T. Evidence of interventions for improving healthcare access for lesbian, gay, bisexual and transgender people in South Africa: A scoping review. *Afr. J. Prim. Health Care Fam. Med.* **2019**, *11*, 1–10. [CrossRef]
44. Lacombe-Duncan, A.; Newman, P.A.; Bauer, G.R.; Logie, C.H.; Persad, Y.; Shokoohi, M.; O'Brien, N.; Kaida, A.; de Pokomandy, A.; Loutfy, M.R. Gender-affirming healthcare experiences and medical transition among transgender women living with HIV: A mixed-methods study. *Sex. Health* **2019**, *16*, 367–376. [CrossRef]
45. Snow, A.; Cerel, J.; Loeffler, D.N.; Flaherty, C. Barriers to mental health care for transgender and gender-nonconforming adults: A systematic literature review. *Health Soc. Work.* **2019**, *44*, 149–155. [CrossRef] [PubMed]
46. Brookfield, S.; Dean, J.; Forrest, C.; Jones, J.; Fitzgerald, L. Barriers to accessing sexual health services for transgender and male sex workers: A systematic qualitative meta-summary. *AIDS Behav.* **2020**, *24*, 682–696. [CrossRef] [PubMed]
47. Watson, C.W.M.; Pasipanodya, E.; Savin, M.J.; Ellorin, E.E.; Corado, K.C.; Flynn, R.P.; Opalo, C.; Lampley, E.K.; Henry, B.L.; Blumenthal, J.; et al. Barriers and facilitators to PrEP initiation and adherence among transgender and gender non-binary individuals in Southern California. *AIDS Educ. Prev.* **2020**, *32*, 472–485. [CrossRef]
48. Kcomt, L.; Gorey, K.M.; Barrett, B.J.; McCabe, S.E. Healthcare avoidance due to anticipated discrimination among transgender people: A call to create trans-affirmative environments. *SSM Popul. Health* **2020**, *11*, 100608. [CrossRef] [PubMed]
49. Ziegler, E.; Valaitis, R.; Carter, N.; Risdon, C.; Yost, J. Primary care for transgender individuals: A review of the literature reflecting a Canadian perspective. *SAGE Open* **2020**, *10*, 2158244020962824. [CrossRef]
50. Bakko, M.; Kattari, S.K. Transgender-Related Insurance Denials as Barriers to Transgender Healthcare: Differences in Experience by Insurance Type. *J. Gen. Intern. Med.* **2020**, *35*, 1693–1700. [CrossRef]
51. Kattari, S.K.; Bakko, M.; Hecht, H.K.; Kinney, M.K. Intersecting Experiences of Healthcare Denials among Transgender and Nonbinary Patients. *Am. J. Prev. Med.* **2020**, *58*, 506–513. [CrossRef]

52. Kattari, S.K.; Call, J.; Holloway, B.T.; Kattari, L.; Seelman, K.L. Exploring the Experiences of Transgender and Gender Diverse Adults in Accessing a Trans Knowledgeable Primary Care Physician. *Int. J. Environ. Res. Public Health* **2021**, *18*, 13057. [CrossRef] [PubMed]
53. Kattari, S.K.; Bakko, M.; Langenderfer-Magruder, L.; Holloway, B.T. Transgender and Nonbinary Experiences of Victimization in Health care. *J. Interpers. Violence* **2021**, *36*, NP13054–NP13076. [CrossRef]
54. She, R.; Mo, P.K.; Cai, Y.; Ma, T.; Liu, Y.; Lau, J.T. Mental health service utilisation among transgender women and sex workers who are at risk of mental health problems in Shenyang, China: An application of minority stress theory. *Health Soc. Care Community* **2022**, *30*, e981–e993. [CrossRef]
55. Gagnon, K.W.; Bifulco, L.; Robinson, S.; Furness, B.; Lentine, D.; Anderson, D. Qualitative inquiry into barriers and facilitators to transforming primary care for lesbian, gay, bisexual and transgender people in US federally qualified health centres. *BMJ Open* **2022**, *12*, e055884. [CrossRef] [PubMed]
56. Serpa, S.; Ferreira, C.M. Micro, meso and macro levels of social analysis. *Int. J. Soc. Sci. Stud.* **2019**, *7*, 120. [CrossRef]
57. Koehler, A.; Strauss, B.; Briken, P.; Szuecs, D.; Nieder, T.O. Centralized and decentralized delivery of transgender health care services: A systematic review and a global expert survey in 39 countries. *Front. Endocrinol.* **2021**, *12*, 717914. [CrossRef] [PubMed]
58. White Hughto, J.M.; Reisner, S.L.; Pachankis, J.E. Transgender stigma and health: A critical review of stigma determinants, mechanisms, and interventions. *Soc. Sci. Med.* **2015**, *147*, 222–231. [CrossRef] [PubMed]
59. Chu, H.; Kirby, L.; Booth, A.; Klepper, M.; Sherman, A.D.; Bower, K.M.; Wright, E.M. Providing gender affirming and inclusive care to transgender men experiencing pregnancy. *Midwifery* **2023**, *116*, 103550. [CrossRef]
60. Garcia, J.; Crosby, R.A. Social determinants of discrimination and access to health care among transgender women in Oregon. *Transgender Health* **2020**, *5*, 225–233. [CrossRef]
61. Hill, B.J.; Crosby, R.; Bouris, A.; Brown, R.N.; Bak, T.; Rosentel, K.; VandeVusse, A.; Silverman, M.; Salazar, L.F. Exploring transgender legal name change as a potential structural intervention for mitigating social determinants of health among transgender women of color. *Sex. Res. Soc. Policy* **2018**, *15*, 25–33. [CrossRef]
62. Garcia, J.; Vargas, N.; Clark, J.L.; Magaña Álvarez, M.; Nelons, D.; Parker, R.G. Social isolation and connectedness as determinants of well-being: Global evidence mapping focused on LGBTQ youth. *Glob. Public Health* **2020**, *15*, 497–519. [CrossRef]
63. Schilt, K.; Lagos, D. The development of transgender studies in sociology. *Annu. Rev. Sociol.* **2017**, *43*, 425–443. [CrossRef]
64. Kidd, S.A.; Veltman, A.; Gately, C.; Chan, K.J.; Cohen, J.N. Lesbian, gay, and transgender persons with severe mental illness: Negotiating wellness in the context of multiple sources of stigma. *Am. J. Psychiatr. Rehabil.* **2011**, *14*, 13–39. [CrossRef]
65. Latorre, R.A.; Endman, M.; Gossmann, I. Androgyny and need achievement in male and female psychiatric inpatients. *J. Clin. Psychol.* **1976**, *32*, 233–235. [CrossRef]
66. Crenshaw, K. Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *Univ. Chicago Legal Forum* **1989**, *140*, 139–167.
67. Moradi, B. (Re)focusing intersectionality: From social identities back to systems of oppression and privilege. In *Handbook of Sexual Orientation & Gender Diversity in Counseling and Psychotherapy*; DeBord, K.A., Fischer, A.R., Bieschke, K.J., Perez, R.M., Eds.; APA: Seattle, WA, USA, 2017; pp. 105–127.
68. Blumer, M.L.C.; Ansara, Y.G.; Watson, C.M. Cisgenderism in family Therapy: How everyday clinical practices can delegitimize people's gender self-designations. *J. Fam. Psychother.* **2013**, *24*, 267–285. [CrossRef]
69. Radix, A.E.; Lelutiu-Weinberger, C.; Gamarel, K.E. Satisfaction and healthcare utilization of transgender and gender nonconforming individuals in NYC: A community-based participatory study. *LGBT Health* **2014**, *1*, 302–308. [CrossRef] [PubMed]
70. Sperber, J.; Landers, S.; Lawrence, S. Access to health care for transgendered persons: Results of a needs assessment in Boston. *Int. J. Transgenderism* **2005**, *8*, 75–91. [CrossRef]
71. Roller, C.G.; Sedlak, C.; Draucker, C.B. Navigating the system: How transgender individuals engage in health care services. *J. Nurs. Scholarsh.* **2015**, *47*, 417–424. [CrossRef]
72. deHaan, G.; Santos, G.; Arayasirikul, S.; Raymond, H.F. Non-prescribed hormone use and barriers to care for transgender women in San Francisco. *LGBT Health* **2015**, *2*, 313–323. [CrossRef]
73. Khobzi Rotondi, N.; Bauer, G.R.; Scanlon, K.; Kaay, M.; Travers, R.; Travers, A. Nonprescribed hormone use and self-performed surgeries: 'Do-it-yourself' transitions in transgender communities in Ontario, Canada. *Am. J. Public Health* **2013**, *103*, 1830–1836. [CrossRef]
74. Aguirre-Sánchez-Beato, S. Trans Terminology and Definitions in Research on Transphobia: A conceptual review. *Quad. Psicologia* **2018**, *20*, 295–305. [CrossRef]
75. Fiorilli, O.; Ruocco, A. Psychosocial issues in transgender health and barriers to healthcare. *Ital. J. Gend. Specif. Med.* **2019**, *5*, 123–130.
76. McGowan, E.; Sanders, S.; Iwatsubo, T.; Takeuchi, A.; Saido, T.; Zehr, C.; Yu, X.; Uljon, S.; Wang, R.; Mann, D.M.; et al. Amyloid phenotype characterization of transgenic mice overexpressing both mutant amyloid precursor protein and mutant presenilin 1 transgenes. *Neurobiol. Dis.* **1999**, *6*, 231–244. [CrossRef]
77. Scandurra, C.; Amodeo, A.L.; Valerio, P.; Bochicchio, V.; Frost, D.M. Minority stress, resilience, and mental health: A study of Italian transgender people. *J. Soc. Issues* **2017**, *73*, 563–585. [CrossRef]
78. Kattari, S.K.; Bakko, M.; Hecht, H.K.; Kattari, L. Correlations between healthcare provider interactions and mental health among transgender and nonbinary adults. *SSM Popul. Health* **2019**, *10*, 100525. [CrossRef]

79. Lindroth, M. Competent persons who can treat you with competence, as simple as that'—An interview study with transgender people on their experiences of meeting healthcare professionals. *J. Clin. Nurs.* **2016**, *25*, 3511–3521. [CrossRef]
80. Baldwin, A.; Dodge, B.; Schick, V.R.; Light, B.; Scharrs, P.W.; Herbenick, D. Transgender and genderqueer individuals' experiences with healthcare providers: What's working, what's not, and where do we go from here? *J. Health Care Poor Underserved* **2018**, *29*, 1300–1318. [CrossRef] [PubMed]
81. Waldman, R.A.; Waldman, S.D.; Grant-Kels, J.M. The ethics of performing noninvasive, reversible gender-affirming procedures on transgender adolescents. *J. Am. Acad. Dermatol.* **2018**, *79*, 1166–1168. [CrossRef]
82. Plemons, E. A capable surgeon and a willing electrologist: Challenges to the expansion of transgender surgical care in the United States. *Med. Anthropol. Anthropol. Q.* **2019**, *33*, 282–301. [CrossRef] [PubMed]
83. Pandya, A.K.; Redcay, A. Access to health services: Barriers faced by the transgender population in India. *J. Gay Lesbian Ment. Health* **2021**, *25*, 132–154. [CrossRef]
84. Available online: https://www.pewresearch.org/short-reads/2022/06/07/about-5-of-young-adults-in-the-u-s-say-their-gender-is-different-from-their-sex-assigned-at-birth/ft_2022-06-07_transandnbadults_01/ (accessed on 10 May 2023).
85. Jobson, G.A.; Theron, L.B.; Kaggwa, J.K.; Kim, H.J. Transgender in Africa: Invisible, inaccessible, or ignored? *SAHARA-J. J. Soc. Asp. HIV/AIDS* **2012**, *9*, 160–163. [CrossRef] [PubMed]
86. Scheim, A.I.; Baker, K.E.; Restar, A.J.; Sell, R.L. Health and health care among transgender adults in the United States. *Annu. Rev. Public Health* **2022**, *43*, 503–523. [CrossRef]
87. Turner, C.M.; Arayasirikul, S.; Wilson, E.C. Disparities in HIV-related risk and socio-economic outcomes among trans women in the sex trade and effects of a targeted, anti-sex-trafficking policy. *Soc. Sci. Med.* **2021**, *270*, 113664. [CrossRef] [PubMed]
88. Macdonald, V.; Verster, A.; Mello, M.B.; Blondeel, K.; Amin, A.; Luhmann, N.; Baggaley, R.; Doherty, M. The World Health Organization's work and recommendations for improving the health of trans and gender diverse people. *J. Int. AIDS Soc.* **2022**, *25* (Suppl. S5), e26004. [CrossRef] [PubMed]
89. Gonzales, G.; Tran, N.M.; Bennett, M.A. State Policies and Health Disparities between Transgender and Cisgender Adults: Considerations and Challenges Using Population-Based Survey Data. *J. Health Politics Policy Law* **2022**, *47*, 555–581. [CrossRef]
90. Carpenter, L.F.; Marshall, R.B. Walking while trans: Profiling of transgender women by law enforcement, and the problem of proof. *Wm. Mary J. Women Law* **2017**, *24*, 5.
91. Sirufo, M.M.; Magnanimi, L.M.; Ginaldi, L.; De Martinis, M. Barriers to inclusive healthcare for transgender people. *Eur. J. Radiol.* **2022**, *153*, 110367. [CrossRef]
92. Divan, V.; Cortez, C.; Smelyanskaya, M.; Keatley, J. Transgender social inclusion and equality: A pivotal path to development. *J. Int. AIDS Soc.* **2016**, *19* (Suppl. S2), 20803. [CrossRef]
93. Asadi, M.; Tabari, F.; Haghani, S.; Heidari, M.E. The impact of empowerment model-based education on quality of life of transgender people under hormone therapy: A randomized clinical trial. *J. Fam. Med. Prim. Care* **2020**, *9*, 2794–2800.
94. Shin, S.; Park, H. Effect of empowerment on the quality of life of the survivors of breast cancer: The moderating effect of self-help group participation. *Jpn. J. Nurs. Sci.* **2017**, *14*, 311–319. [CrossRef] [PubMed]
95. Castro-Peraza, M.E.; García-Acosta, J.M.; Delgado, N.; Perdomo-Hernández, A.M.; Sosa-Alvarez, M.I.; Llabrés-Solé, R.; Lorenzo-Rocha, N.D. Gender Identity: The Human Right of Depathologization. *Int. J. Environ. Res. Public Health* **2019**, *16*, 978.
96. Costa, D. Diversity and Health: Two Sides of the Same Coin. *Ital. Sociol. Rev.* **2023**, *13*, 69–90.

Disclaimer/Publisher's Note: The statements, opinions and data contained in all publications are solely those of the individual author(s) and contributor(s) and not of MDPI and/or the editor(s). MDPI and/or the editor(s) disclaim responsibility for any injury to people or property resulting from any ideas, methods, instructions or products referred to in the content.